General queries to provide context:

1) **Why was there a gap of 3 years between OBC and FBC?**

   This represents the formation of the Trust in July 2011, with the consequent build-up of resources and understanding to formulate a desired option; coupled with the lack of clarity from the centre regarding the status and costs surrounding both the existing LSP product, and the future state LSP product.

   This situation was exacerbated by a significant number of changes that took place within the executive team during the period; this resulted in a number of "false starts"; with the options being reviewed several times as both the local and national picture changed over time.

   It should also be noted that the LSP has only relatively recently been willing to share what the costs of their product are going forward, as a result of the HSCIC driven exit strategy.

2) **Has the progress to date section identified any more costs? Eg data warehousing**

   Your example of Data Warehousing is already included within our operational informatics delivery; other costs which may be incurred e.g. project management, training resources etc.. are already factored in.

   The gaps we are aware of relate to integration and messaging between the different systems that are in use across the LHE; and the provision of mobile devices. The choice of RiO has enabled a degree of mitigation in respect of some of these risks as the supplier has significant experience in the integration aspects of the RiO product as many of the systems used locally are used elsewhere.

3) **As a general point the FBC talks about an August 15 start for implementation.**

   This date reflected the award process and implementation plans that were developed around the programme; the requirement for the TDA to review the procurement process was picked up after the dialogue phase had commenced.

   The prices that have been supplied by the suppliers are valid for 120 days; therefore if they are not notified by 26th October we will have to ask them if they are willing to extend their offer price for an additional period of time.

   We are constructing a revised implementation programme that takes account of the delayed start – in effect the first service would now be implemented in early January rather than early November.

   The implementation start would be mid November rather than mid August on the assumption that the FBC is approved by the TDA within the timeframe.

4) Constraints on page 20, unclear how these link to the risk register.

Constraints	Risk Register reference No.
Engaging clinicians	EPR/R4 & R8
Workforce Capacity	EPR/R15 and R22
Training	EPR/R8 & R15
Implementation Resources	EPR/R2 & R7 & R16 & R21& R23
Supplier Issues	EPR/R12 & R14 & R19 & R20
Time constraints	EPR / R1 & R13

5) Page 20 unclear how the Trust will manage dependancies.

- EPR contract management and change control

  This will be managed by the application of consistent PRINCE2 and MSP practices; the project is being led by an experienced and well qualified IM&T Programme Manager with considerable experience of leading and managing complex IT deployments across multiple organisations with multiple suppliers.

- Understanding of trust business and clinical requirements

  Product requirements were clinically driven with representation from all clinical groups; together with corporate colleagues ensuring that areas like RTT and performance management were included in the product specification.

- Deployment resources

  Are based on experience of delivering complex IT projects across multiple organisations e.g. NPfIT deployments; the identification of the supporting resources that are required for this type of deployment are understood internally, and have been confirmed by the suppliers during the dialogue process. These are included in the high level project plan.

- Technical expertise and support

The Trust has adequate IT technical expertise and support available internally for this type of deployment; the solution is hosted, therefore the technical support is generally around connectivity and end user devices. Additional technical support is available from the supplier should the need arise.

- Informatics expertise

  The informatics team will be stretched by this implementation, however by utilising a phased deployment approach the existing resources are expected to manage the implementation and maintenance of the chosen product.

- Training materials

  Training materials will be developed once the supplier has been formally notified; the Trust is fortunate in having an experienced and competent internal training team who are experienced in the development of training materials for IT solutions, which will be undertaken in conjunction with the supplier.

- Communications materials

  Similar to the training materials these will be developed in-house in conjunction with our communications lead and with assistance from the supplier; obviously a number of staff communications have already taken place both as part of the selection process and a wider engagement programme.

- System administration

  This falls under the Informatics umbrella and as previously stated the implementation on a phased basis will allow the team to migrate from systems admin of legacy systems to systems admin of the Rio product.

Extract from Appendix 9.2

9.2.1 Engaging Clinicians

Engagement with clinical staff is a key issue in ensuring successful planning, deployment and benefits realisation. The Trust's approach to engaging key stakeholders is outlined in the management case. A number of Clinicians have been actively involved in the planning process including: -

- The options appraisal
- Engagement with Clinical Advisory Group
- Quality assurance of the EPR functionality

- Product evaluation and selection

Clinicians will continue to be fully engaged with the implementation and deployment planning for the EPR project. The structure of the project ensures that the senior roles are clearly defined in terms of clinical services at both project team and project board levels.

9.2.2 NHS Workforce Capacity

The NHS is already stretched trying to maintain services, meet targets and modernise, and therefore workforce capacity has to be a potential constraint.

The Trust EPR project is an enabling initiative for the wider transformation programme. The Trust is working closely with the wider Local Health Economy – Future Fit programme and is developing staff so that they can better understand/use the potential of IM&T to improve patient care.

9.2.3 Training

The resources available for training within the Trust are limited. In particular there are constraints on the number of training rooms available and the ability to release staff from their operational duties. These constraints are being mitigated by phasing the EPR project deployments and the recruitment/funding of additional IM&T trainers.

9.2.4 Implementation Resources

IM&T implementation requires significant resources from within the Trust – as evidenced by the NPfIT systems deployment within the Trust. Although the suppliers may be contractually required to implement systems they cannot achieve this without significant input from Trust IM&T staff that provide technical support and information such as the data migration plans, technical details and infrastructure details.

An assessment of project management and facilitation resources has been undertaken for this FBC – resulting in identifying some additional project management and project resources to mitigate this possible constraint.

9.2.5 Security

The Implementation of the EPR will not compromise the Trust's secure networks and locations. The EPR is a web-based solution that is hosted remotely and will be accessed securely via the NHS N3 network.

System security will be maintained as resilience and disaster recovery is provided by the supplier's remotely hosted system.

The contractual agreement in place with the suppliers requires that the latest NHS standards around the confidentiality and security of patient records are maintained at all times.

Investments to ensure service continuity and security of remaining legacy systems and services have been included in this FBC.

9.2.6 The successful implementation of new Infrastructure

An adequate technical infrastructure will be required to support the implementation of the EPR. This infrastructure is needed to support the users accessing the service and the messaging upon which the EPR relies.

There are therefore three key technical dependencies:

- N3 connectivity across all locations; this delivers the resilient "wired" connectivity with the appropriate bandwidth. This connectivity is in place.
- The desktop and mobile devices (e.g. PCs, Tablets) and other access devices to be used by staff. At the moment the desktop devices and Laptops are available; the Tablet devices are currently under review.
- Wi-Fi networking is in the process of being deployed across the Trust estate; and it will be fully deployed by Q4 2015/16.

The FBC includes funding and activities to ensure the above standards are met in time for go-live.

9.2.10 A nationally agreed approach to Security and Confidentiality

A nationally agreed approach to patient confidentiality in respect of electronic records and sharing of data is still to be developed; in particular a solution to the patient consent issue is required, although some of these issues are being addressed through the Caldicot2 report.

6) What is the timetable for the clinical strategy detailed on page 16?

The draft version is likely to be presented to the Quality & Safety Committee in November 2015.

7) The risk register is rag rated, scored, and includes mitigations but no estimated costs associated with the risks.

The Trust process for risk management operates on a likelihood and consequence model; these factors are then scored and combined to provide a risk rating; mitigation actions are then factored in to provide a mitigated risk score (or RAG rating). Cost in itself is not an individual item; it is included

within the consequence factor; therefore higher potential cost would equal higher potential consequence.

8) Evidence of learning from other organisations in more detail.

The Trust has recognised that when undertaking a project of this type and complexity it is crucial that any lessons that can be drawn from previous projects of a similar nature are taken on board and applied to the current project. Only in this way can full value be obtained from past experiences and can earlier mistakes or problems be avoided.

There are a number of crucial lessons that must be learned from past major public sector IT implementation projects, which are addressed by following the governance and assurance processes surrounding this FBC and adoption of PRINCE2 project management standards.

Local lessons arising from the Trust's previous systems deployments over the past several years have been incorporated into the proposed phased deployment approach, project management/support arrangements and resource assumptions. The latter are summarised below: -

a) The need for robust communications to establish the credibility of the system and the deployment team
b) The need to standardise processes to facilitate the transformational change management that is required
c) The benefits of concentrating resources on early adopter deployments before moving on to wider clinical deployments
d) The importance of good Performance Management information and the embedding of good data quality standards
e) The importance of a strong performance management framework and standards for documentation covering targets endorsed at senior level
f) The key importance of having a critical mass of properly skilled and trained staff are: -

    i. They can be centrally managed
    ii. They have regular and direct access to operational teams
    iii. They are recruited to consistent standards to help ensure flexibility, adaptability, responsiveness and project focus
    iv. They are able to establish, support and measure data entry standards
    v. They able to support related projects [informatics data quality and robust testing]

The project planning has also taken into account lessons learned from other Trusts implementing a similar EPR.

This process has been enhanced by the visits to the reference sites which enabled clinician to clinician dialogue to take place, allowing for some in-depth experiential learning and knowledge sharing.

Across the local economy the current position is:

Shrewsbury and Telford Hospitals (Acute)

SEMA Helix PAS – Shrewsbury and Telford Hospitals are committed to the SEMA system. This PAS is only used by two Trusts within the UK, it does not have a Community module and any development would have to be paid for.

Robert Jones and Agnes Hunt (Acute)

iPM and Graphnet. The RJAH are planning to stay with iPM and the Graphnet EPR. They have started to develop parts of Graphnet and state that they are seeing increasing benefits in using the Graphnet solution.

The current position of some of the Community and Mental Health organisations in the wider region is given below:

South Staffordshire and Shropshire Healthcare NHS FT have implemented RiO.
Birmingham and Solihull Mental Health NHS FT have implemented RiO.
Birmingham Community Healthcare NHS Trust have implemented RiO.
Staffordshire and Stoke on Trent Partnership NHS Trust have implemented RiO

It seems clear that outside of an acute setting RiO is offering the required functionality that is important for Trusts operating in a community environment.

Specific queries for completing the report:

- **Additional narrative about how the system fits with NHS Trust strategy, relationship with community wide/national strategies?**

  Both National and Trust Strategies require an exit plan from the legacy CfH products before the contract end in July 2016; this could be by either replacing the LSP products or by continuing with them and having new contractual arrangements. In our case the LSP is CSC and the product is iPM.

  It is clear that over the past ten years while the Trust has operated the LSP products that they are primarily designed to be used in Acute settings; and despite repeated requests the products have not been modified sufficiently to effectively support a Community Trust in having a true EPR.

  Our IM&T Strategy is based around providing the right information to the right person when they need it. This is the also the cornerstone of local community wide working, and national strategies. We do not need, nor are we seeking to implement a single LHE wide product; our objective is to ensure that the product we implement has the capability to message and interwork with other systems, both current and future.

  Our implementation will not only deliver our local objectives, but it will also enable the Trust to meet the national agendas around paper light and patient access.

The following are the key points we have considered from our IM&T Strategy:

- The urgent need to replace the iPM PAS system. This system will be withdrawn from use from within the current supplier's services in July 2016

- The requirement to integrate / interwork with other partners in the local health economy

- The need to transform the way our staff work; by providing a system that fully supports mobile disconnected working

- The opportunity to plot a clearer, phased and quicker pathway for delivering the Trust's ambition of a single service user index and electronic records system.

- A single, secure collection point and repository for clinical information regarding service users.

- A single source of key clinical information that is available 24/7 from all the Trust's operating bases – including mobile working.

- A system that is able to better support the clinical and risk management of service users who often have complex conditions, multiple records and engage with different parts of the service.

- The basis for more consistent multi-agency and collaborative working to support service users.

- More reliable and up to date clinical performance information

- Clear migration pathways for all legacy systems – including those presently in use in specialist service areas e.g. Child and Adolescent Mental Health Services (CAMHS)

- **What are the consequences if the investment does not happen?**

  The trust will have to continue using the legacy systems which are not fit for purpose; and will incur increased costs as a result.

  The Trust will not be able to deploy mobile working as none of the legacy systems support mobile disconnected working.

  The Trust will not be able to deliver on the "paper light" agenda.

  The Trust will not be able to share electronic clinical records effectively with partner organisations; as it won't have an electronic clinical record.

  The Trust will not be able to deliver electronic discharge notifications across all services.

The Trust will not be able to provide patients with access to an electronic version of their care record.

- **Where relevant what commissioner support is there and other stakeholder engagement and buy-in has been gained.**

  As the EPR is an internal business development we have kept our main commissioners and other stakeholders informed of our intentions and progress, throughout the procurement process.

  It has been emphasised during the procurement dialogue that whatever EPR product was chosen one of the prime requirements was for it to be able to message effectively with all the stakeholders that we work with.

  This requirement is clearly articulated within the technical specification.

- **What are savings in terms of pay, non-pay and overheads compared to position if investment is not made and how do these savings compare to the trust cost base. How will savings be achieved?**

  If the investment is not made there will be no corresponding savings in pay, non pay and overheads compared to the current position.

  Conversely, if we do not proceed with the EPR project there will be a cost pressure as the cost of "do nothing" (maintaining legacy systems) exceeds the case for investment by £23k as set out in the table below.

Heading	EPR £'000	Legacy £'000	Variance £'000
Capital	1,366	0	(1,366)
Revenue	1,555	2,944	1,389
Total Cost	2,921	2,944	23
Discount Factor	0.96	0.91	
Net Present Cost	**2,921**	**2,944**	**23**
Discount Rate	***3.50%***		

- **What are the downside risks, what is the impact of these risks on the investment appraisal? Any mitigation?**

  N/A – no downside scenario is included in our LTFM

- **What other Non-financial benefits will the investment deliver?**

  Enable the Trust to share electronic information across the local health economy and ensure the Trust is in a position to fully support the development of a local integrated care record

  Provide a modern user interface for users, by deploying a current generation product the end user will no longer be required to navigate around a system(s)

that were designed over a decade ago, before technologies like “touch screen navigation” were the norm

Enable patients access to an electronic version of their records through utilising a “portal” approach; this element will be implemented in line with national requirements for patients access to their records

Reduce clinical risk by consolidating the patient index and systems from 3 separate PAS systems to one, the implementation of the single EPR will remove this existing risk, and in so doing will remove the administrative overhead that is associated with this maintenance activity

Manage the clinical risks from incorrect record retrieval, the single EPR removes this risk as there is only one record for each patient/client

Enable faster record retrieval and fewer incidents of duplicate records being set-up, the single EPR virtually eliminates the risk around duplicate records and being a digital record the speed of caseload retrieval is almost instantaneous

Improve activity recording across services by uniformly capturing the clinical and administrative data in one record that covers the majority of the services that the Trust provides

Enable complete and comprehensive recording of referrals for inpatient, outpatient, community and therapy services in one record, which will reduce the amount of time that is spent trying to understand the pathways that exist for our services, and will ensure that we can provide a complete picture of the services that we provide both internally and to our Commissioners

Provide efficient Waiting Time and Waiting List Management, there will be a reduction in the time spent waiting for appointment/service provision due to the ability to streamline administrative procedures and operate internal transfers more efficiently

Provide more efficient admission (from other Inpatient/Outpatient facilities, Other Community Services, or GPs) due to the electronic exchange of more complete and standardised data, coupled with the ability to plan across all locations. The transmission of the required information electronically from system to system will generate efficiencies by removing the existing manual processes

Deliver enhanced internal information flows and improve Delayed Discharge Management between Trust Services, as the EPR is a single record which is viewable and accessible across all the Trust services, and can link to partner organisations, this will reduce the time that is currently taken to pass information around the various systems and will result in speedier decision making

Improve information flows (to Commissioners, GPs, and Service Users) about discharge dates and associated information which may be required to ensure a smooth transition along the care pathway

Improve NHS Number coverage as a result of the single record being utilised across the Trust, it is simpler and more efficient to operate data quality reviews across a single index, rather than across multiple ones

Enable clinical coding in Outpatients and other areas by moving to an EPR that supports the latest clinical coding requirements, including the comprehensive recording of outpatient diagnosis

Ensure the continued accuracy of the Trusts recording of waiting lists for inpatient, outpatient and therapy services, which will be enhanced by operating a single EPR solution; where the processes and associated rules can be readily disseminated across the Trust

- **Some narrative on clinical engagement and how the system/ preferred option will integrate with other Trust systems.**

  As we have mentioned elsewhere the project team is led by one of the Trusts senior clinical leads; the Executive Sponsor is the Director of Nursing and Quality.

  During the dialogue process a number of clinical development workshops were held; where clinicians from across the Trust, from all disciplines were engaged with developing the product specification, including deciding the mandatory and discretionary functionality. (The actual criteria are provided in the Award Notice – Appendix 11 embedded document – there are several hundred rows of clinical requirements and functionality).

  The product evaluation team included a multi-disciplinary group of clinicians (medical; nursing and therapies) to ensure that the process remained a clinically driven one.

  The EPR will replace three existing PAS systems; it will become the primary clinical record for the majority of our services. The Trust does not operate a wide range of other systems; we have our PACS and Pathology services from one of the Acute Trusts and the integration with these services has been specified within the product specification.

  Where other services are utilising niche systems (e.g. Community Equipment Loan Stores, Wheelchair Services) we will look to develop integration over time. In the short term we have identified the ability to message with these systems as a requirement.

  The preferred option is already widely deployed across the NHS, both locally in a number of neighbouring Trusts, and nationally, the supplier has significant experience in systems integration with both secondary and primary care.

- **There are no critical success factors identified.**

These are taken to be the “Mandatory” items within the product specification and they are shown in detail in the Award Notice.

There are other critical success factors within the procurement process which are shown below

Target Date	Milestone	Complete
26th May 2015	Dialogue stage closes (extended to cover final questions)	✔
29th May 2015	Invitation to Submit Final Tender document (ITSFT) signed off by Project Board	✔
1st June 2015	The Authority issues this ITSFT following the closure of the Dialogue Stage	✔
10th June 2015 to 11th June 2015	Initial evaluation of Technical Specification mandatory responses	✔
22nd June 2015	Deadline for receipt of requests for clarification from Tenderers regarding the ITSFT inviting Tenders	✔
29th June 2015	Deadline for receipt of final Tenders	✔
6th July 2015	Supplier Presentations and Authority Q&A Session	✔
9th July 2015	Project Board Challenge Session	✔
20th July 2015	Date for completion of evaluation	✔
27th July 2015	Project report of Authority with recommendations to Board meeting	✔
18th August 2015	Final Full Business Case sent to TDA for approval	
Subject to TDA sign-off	Letters issued regarding notification of award decision and preferred Tenderer	
	Standstill Period	
	Contracts concluded with preferred Tenderer	

	Contract start date	
	First Service goes live	

Further implementation critical success factors will be included in the operational deployment plan; e.g. data migration; service future state business process mapping completed, future state clinical documentation completed, service go live.

These are some of the generic processes which will be undertaken across each service area (see Service Implementation plan Appendix 9.5); the details of which will be worked up during the mobilisation phase.

- **There is no sensitivity analysis included.**

The financial impact of risks will be estimated in the Risk Register but at this stage no sensitivity analysis has been undertaken. However, value for money has been assessed on the basis that the cost of 'do nothing' exceeds the cost of the project over its economic life.

It should also be noted that the supplier cost element is on a fixed price basis and our internal resources can be flexed according to demands of the project.

- **Narrative to outline the justification of selection of the preferred option and the process from a long from long list to short list evaluation**.

This is articulated within the scoring matrix that is included within the award documentation (Appendix 11 – Award Notice); which itself is the result of several months of product demonstrations, analysis, site visits, dialogue, clinical evaluation, culminating in the ITT submissions from suppliers, which were then scrutinised by an evaluation panel.

The Rio product has been chosen on the basis of a clinically driven procurement; which placed the greatest significance on clinical functionality rather than price, although the product cost was a significant factor in the procurement process. There is clearly an attainment of value for money when comparing the preferred solution to the "Do Nothing" option.

The main areas of mandatory functionality where there is a clear difference in the respective supplier products are around:-

- Bed Management and associated basic patient management functions
- Caseload management, including discharges
- Clinical records management; including coding, tracking and searching

- Minor Injuries functionality both clinical and reporting
- Mobile working
- Waiting list management

The narrative below is an extract from the Award Notice and this explains the long list to short list evaluation process:-

3. Summary of Offers

3.1 On 22nd July 2013, the Authority published an advert in the Official Journal of the European Union in respect of the procurement of an EPR/IDCR (Electronic Patient Record/Integrated Digital Care Record) Ref:2013/S 142-247446.

3.2 The Authority received nine (9) completed Pre-Qualification Questionnaires from potential suppliers and evaluated these Pre-Qualification Questionnaires in accordance with evaluation criteria set out in the document. The suppliers that submitted were:

Capita Healthcare Solution
ALERT Life Sciences Computing
Sopra Group Limited
Egton Medical Information System
FileTek UK Ltd
Advanced Health and Care Limited
CSE-Healthcare Systems Limited. (Became : Servelec Healthcare Limited)
Hicom Technology Limited.
Oasis Medical Solutions.

3.3 The following three (3) suppliers failed to meet the minimum criteria required in the Pre-Qualification Questionnaire and were rejected from the process. All of the remaining six (6) suppliers were shortlisted to progress to the next stage (ITPD)

ALERT Life Sciences Computing –Financial Assessment
FileTek UK Ltd- Technical Capability Assessment
Hicom Technology Limited - Financial Assessment

3.4 The Authority then postponed the process due to a review of the National Scheme however in 2014 a decision was made to continue with the process. Legal advice was sort from Mills and Reeves and a refreshed D& B report obtained for the six (6) potential suppliers.

3.5 The Invitation to participate in dialogue (ITPD) document was written and reviewed with Mills and Reeves prior to issue to the PQQ shortlisted suppliers on the 9th December 2014.

The suppliers were invited to an open day on the 12.01.15 where the Competitive Dialogue process was explained.

3.6 Potential Suppliers were asked to review the ITPD and confirm if they wished to continue to participate in the dialogue process. The following suppliers declined to participate at this stage.

Oasis Medical Solutions
Sopra Group Limited

3.7 The Dialogue stage consisted of individual 1 to 1 meetings, scripted demonstrations, and site visits. Minutes were taken for each meeting held and every supplier was treated equally.

During this open stage Capita Healthcare Solution decided that they could not meet the requirement during the dialogue and rejected the tender.

3.8 The ITPD stage was closed on the 28th May 2015, suppliers were asked to submit the mandatory requirement submission of the quality evaluation (as this element was not subject to change) and a declaration of their intention to proceed in the process, the following suppliers submitted:

Egton Medical Information System
Advanced Health and Care Limited
Servelec Healthcare Limited (formally CSE-Healthcare Systems Limited)

3.9 Subject to the ERP board approval the final ITSFT tender document was issued to the above suppliers on the 01St June 2015 with a deadline for final submission of the 29th June 2015

- **The report should include the following tables:**
    - **A table which outlines the ranking and scorings of the shortlisted options (Options being the 3 shortlisted providers) as per example below.**

The table requested (Options Appraisal Summary) already appears in the Appendix 11 – Award Notice (shown below), in the form required by the OJEU procurement process; this is in effect the options appraisal summary – unless we are advised otherwise by our procurement service / legal advisors we will not be able to change it to include additional selection criteria.

Table A: Options Appraisal Summary

- **Summary of the NPV calculation for each option:**

The preferred option in terms of supplier has been selected based on the OJEU procurement process. This is a legal process with a range of selection criterion which does not lend itself to NPV comparison.

However, once the preferred supplier has been selected (based on the OJEU procurement process) the options for consideration are

a) Proceed with the EPR implementation or

b) Do nothing, ie retain our legacy systems.

The NPV for these options are set out in the table B below

Table B: Net Present Value Summary

Heading	EPR £'000	Legacy £'000	Variance £'000
Capital	1,366	0	(1,366)
Revenue	1,555	2,944	1,389
Total Cost	2,921	2,944	23
Discount Factor	0.96	0.91	
Net Present Cost	**2,921**	**2,944**	**23**
Discount Rate	***3.50%***		

- **Provide information in the report on the cash releasing and non-cash releasing benefits and what these are and how they have been derived. How are these phased across the appraisal period? How have these been calculated? Benefits are qualitatively stated with high level cash releasing benefits stated however there is no full benefits realisation plan detailing actions, who is responsible and financial benefits.**

The only savings included in the FBC are non pay cost associated with current CAHMS PAS and Hospital PAS. The savings which amounts to £276k over 5 years will be achieved by decommissioning legacy systems on completion of the EPR installation, see table C below.

Precise details of cash releasing savings from EPR will be determined and prioritised by the Trust's Project Board and as such they have not been included in the FBC. The Project Board will identify savings in more detail and the EPR benefits work stream will ensure their achievement is monitored.

These benefits will be derived mainly from the following efficiencies that EPR will drive.

Allow for the greater use of mobile working – thereby improving efficiency and patient/client experience.

Introduce new support functions enabling – for example - improved referral management, case note tracking and bed management.

Improved staff efficiency through reduced administration and quicker access to clinical records/information.

A single, modern, secure inpatient, outpatient and community system which holds an integrated record. This will save time from accessing multiple systems and manual records.

Opportunities to simplify, standardise and improve existing clinical processes leading to improved efficiencies and better patient experience/patient care.

Above efficiencies will release clinical staff time to deliver more activities and or new services.

Table C: Cash Releasing Benefits

Heading	2015-16 £'000	2016-17 £'000	2017-18 £'000	2018-19 £'000	2019-20 £'000	2020-21 £'000	Totals
Savings from decomissioning of legacy systems		(47)	(67)	(67)	(67)	(28)	(276)
Total Incremental Cost		**(47)**	**(67)**	**(67)**	**(67)**	**(28)**	**(276)**

Table D: Non-Cash Releasing Benefits – *Example from the FBC*

Option	2014/15 £000	2015/16 £000	2016/17 £000	2017/18 £000	2018/19 £000	2019/20 £000	2020/21 £000	2021/22 £000	2022/23 £000	Total £000
District	0	0	190	250	250	250	250	250	250	**250**

Nursing										

The non-cash releasing benefits are reflected in the FBC benefits section Fig 1. – these relate to the potential efficiency gains that can be utilised to improve both quality, and meet currently unmet demand, and future growth.

- **There is a lack of clarity over post implementation evaluation arrangements;**

The post implementation evaluation will take place as part of the normal project lifecycle; as each service will have its own implementation path so there will be individual service evaluations; these will in turn feed into the lessons learnt for the following services; and into an overarching process which will span the entire project.

The evaluation will take the form of both ad-hoc lessons learnt feedback; and structured audits; with sample deep dives where the benefits realisation is problematic.

Project Deployment Lifecycle and Artifacts

Process of Engagement

- **the investment proposal demonstrates a high level of engagement with clinical staff and the use of appropriate staff and patient feedback and for EPR schemes demonstrates how the proposed system will integrate with the Trusts other information systems.**

As we have mentioned elsewhere the project team is led by one of the Trusts senior clinical leads; the Executive Sponsor is the Director of Nursing and Quality.

During the dialogue process a number of clinical development workshops were held; where clinicians from across the Trust, from all disciplines were engaged with developing the product specification, including deciding the mandatory and discretionary functionality. (The actual criteria are provided in the Award Notice – Appendix 11 embedded document – there are several hundred rows of clinical requirements and functionality).

The product evaluation team included a multi-disciplinary group of clinicians (medical; nursing and therapies) to ensure that the process remained a clinically driven one.

The EPR will replace three existing PAS systems; it will become the primary clinical record for the majority of our services. The Trust does not operate a wide range of other systems; we have our PACS and Pathology services from one of the Acute Trusts and the integration with these services has been specified within the product specification.

Where other services are utilising niche systems (e.g. Community Equipment Loan Stores, Wheelchair Services) we will look to develop integration over time. In the short term we have identified the ability to message with these systems as a requirement.

The preferred option is already widely deployed across the NHS, both locally in a number of neighbouring Trusts, and nationally, the supplier has significant experience in systems integration with both secondary and primary care.

Patient Care, Quality and Care delivery system benefits

- **the investment proposal is consistent with the NHS Trusts clinical strategy and supports the provision of high quality care;**

  Yes the procurement is in line with the Trusts proposed clinical strategy and supports the provision of high quality care. The RiO product outperformed the other products in terms of its ability to meet both the existing and future Trust requirements, and will enhance the safety of our patients.

- **there is a clear and credible approach to enhancing the delivery of patient care and performance standards;**

  Yes; the primary reason for the implementation of the RiO product is to improve patient care, by delivering a seamless electronic patient record across the majority of our services, which will be able to effectively interwork with our partner organisations.

- **issues relating to the sustainability of the wider local health economy have been addressed and the proposed solution adequately assists the health economy in managing present and future issues;**

  Yes; the LHE are aware of the RiO implementation and its potential contribution to a shared care record and the requirement to ensure the delivery of the LHE digital roadmap for paperless working by 2020.

- **the quality, safety, productivity, affordability, value for money and workforce implications associated with the investment proposal are robust, well thought through and described within the business case;**

  Yes all these areas have been addressed within the EPR procurement exercise and the FBC and associated documents articulate all of these issues in detail.

- **the NHS Trust has the resource and capacity to deliver the investment programme within a realistic timeframe.**

  Yes; the Trust has the capability, capacity and resource to implement the RiO solution within the planned timeframe. Although the period for the implementation of the RiO product to replace the legacy LSP iPM product is constrained by the national timeframe; it is still achievable within our planned deployment resources.

Provision proposal and best practice

- **Which is the preferred option and why?**

The FBC updates the Outline Business Case (OBC) discussed by the Trust Resource and Performance Committee in July 2012.

It confirms that the preferred option selected following the agreed product selection and procurement process is for the Servelec product (Rio).

This product was been chosen on the basis of a clinically driven procurement; which placed the greatest significance on clinical functionality rather than price, although the product cost was a significant factor in the procurement process.

There is clearly an attainment of value for money when comparing the preferred solution to the “Do Nothing” option.

The main areas of mandatory functionality where there is a clear difference in the respective supplier products are around:-

- Bed Management and associated basic patient management functions
- Caseload management, including discharges
- Clinical records management; including coding, tracking and searching
- Minor Injuries functionality both clinical and reporting
- Mobile working
- Waiting list management

When taking all of these and the other clinical factors into account the RiO product clearly met or exceeded the required criteria.

- **Is the NHS Trust option appraisal process robust?**

The following is an extract from the Award Notice – it describes the appraisal process and associated scoring mechanism.

The Offeror’s submissions were assessed in relation to specific requirements set out in the ITSFT document on quality and price. These were:

Award Criteria	Weighting
Technical and Quality	60%
Commercial (Total Cost)	40%

The quality and technical evaluation was assessed in accordance with a pre-determined model with the following sub criteria:

Award Criteria Headings	Sub-Criteria	Sub-Criteria Weighting	Total Weighting

Technical & Quality	Mandatory Information Requirement	20%	60%
	Ability to Meet Discretionary Requirements	15%	
	Delivery and Implementation	15%	
	Training and Support and MI	10%	

Scoring Model for Tender Response Document Method Statements			
10	**5**	**1**	**0**
Method statement addresses all aspects of the requirement with a comprehensive level of detail. The level of detail means that the Authority has no reservations in relation to the method statement for meeting the requirement.	Method statement addresses all aspects of the requirement with a comprehensive level of detail being provided for most aspects. However, the level of detail / omissions relating to one or more aspects of the method statement means that the Authority has some minor reservations in relation to the method statement for meeting the requirement.	Method statement does not address all aspects of the requirement with a comprehensive level of detail. The level of detail / omissions relating to one or more aspects of the method statement means that the Authority has some major reservations in relation to the method statement for meeting the requirement.	Failure to provide a method statement.

In addition to the quality evaluation the tendered prices were also evaluated and assessed in accordance with a pre-determined model detailed below:

Award Criteria Headings	**Sub-Criteria**	**Sub-Criteria Weighting**	**Total Weighting**

Commercial	Total cost including, Annual Core Licence, Hosting, Client Licence model and Maintenance and Support	40%	40%

The evaluation process results in comparative quality and price scores for each tenderer, and the tenderer scoring the highest combined score was recommended for award of the Contract.

- **Is there evidence of innovation and best practice in the business case which can demonstrate a NHS Trust has put patients at the centre of their investment proposal with the aim of delivering the highest standards of NHS care?**

The FBC articulates the clear vision of the Trust in placing the patient at the centre of our considerations; the unambiguous requirement to ensure the procurement is clinically driven, and focused on delivering benefits to patients across all of our services resulted in our product choice.

RiO enables the Trust to have the opportunity to move more quickly towards the Trust‘s ambition of a single electronic service user index and records system, the benefits of which are: -

- Improved patient experience across multiple pathways
- Easier access to records for clinicians across multiple locations
- Reduced clinical risks to patients and management overheads arising from fragmented paper and electronic systems
- A framework for standardisation and innovative service re-design of clinical and administrative processes across the Trust; including but not limited to the wide spread introduction of mobile connected / disconnected working.

RiO will enable the Trust to align with national Information Management & Technology (IM&T) strategies, particularly with regard to moving to “paper-light” and providing patients with electronic access to their records.

RiO provides a technical solution that can integrate/interwork with other clinical systems both within the Trust and across the Local Health economy (other Trusts, GP Practices, Social Care etc..) which will allow the Trust to actively participate in the creation and utilisation of the LHE digital roadmap to improve both the clinical delivery and efficiency of patient care.

Finance, value for money and affordability

* What are the CIP implications? Comment on overall CIPs position and impact upon business case.

The affordability of the FBC does not rely on the achievement of cash releasing benefits/CIP, although these benefits are expected to play a role in delivering the Trust efficiency programme over future years.

The financial assessment of the FBC is based on incremental cost which concludes that it is affordable on the basis that the project cost is lower than the 'do nothing' option.

Additional Documents to be provided -

- Minutes from the board meeting where the Board Approved the FBC (embedded document in the checklist won't open) - Attachment 1 - Extract from Shropshire Community NHS Trust Board Papers 30th July 2015 (Part 2)

Extract from Shropshire Community

- NPV working document

Copy of NPV Workings AS.xlsx

- Financial Case states that all VAT is recoverable, please can you provide proof that an external entity has confirmed this (i.e. Trust Auditor or a VAT specialist)

  The hosting & support charges from the supplier are reclaimable under heading 14 (computer services in connection with the collection, preparation and processing of data) in line with HMRC rules.

  Software & implementation costs are also recoverable if they are bespoke. Although the software is bought, and is used by other organisations, it is just a framework and cannot be used without further design work, customisation and building the system to meet our requirements

- Commissioner Support letter, if available –
  Not applicable

Benefits of the project

Goal	Deliverable	Description of Benefit	Type	Financial		Non-financial	Tracked in benefits realisation plan	Value for total benefits £000s
				Non-cash releasing	Cash releasing			
EPR Implemented	1. Single EPR	• To replace three separate PASs with a single modern EPR, with the consequent reduction in duplication and risk reduction that can occur when records transfer across systems			**£276K**		**Y**	
		• To provide a modern sustainable and well supported technical platform for a single integrated EPR, utilising current generation technologies that are provided by a well-established clinical systems supplier, that has a proven track record in systems delivery and ongoing support				**y**		
		• To provide opportunities to simplify, standardise and improve existing clinical processes leading to improved patient experience and patient care, through analysing current processes and deploying "LEAN" methodologies in the process mapping and design phase, the patient/client				y		

Goal	Deliverable	Description of Benefit	Type	Financial		Non-financial	Tracked in benefits realisation plan	Value for total benefits £000s
				Non-cash releasing	Cash releasing			
		pathway can be optimised - see FBC Fig. 1 – Potential impact of implementing electronic diaries – page 20						
		• To enable the Trust to share electronic information across the local health economy and ensure the Trust is in a position to fully support the development of a local integrated care record and contribute to the LHE Digital Roadmap				y	y	
		• To improve bed and clinic management trust wide through using one co-ordinated bed and clinic management system, this will allow the trust to have an over-arching view of these resources and their availability, and will promote and enable effective resource planning including : o Better bed management f**rom** better predictability of bed availability o Bed Occupancy is visible across all sites				y		

Goal	Deliverable	Description of Benefit	Type	Financial		Non-financial	Tracked in benefits realisation plan	Value for total benefits £000s
				Non-cash releasing	Cash releasing			
		o Delayed Discharges can be more effectively reported o Delayed Admissions can be more effectively reported o All services are visible and this promotes effective transfers between services						
		• To become “paper-light”; the deployment of the EPR will allow the trust to embark on the first stage of its digital journey; with the majority of new cases (and the record content) being held digitally rather than on paper, significantly reducing storage costs and improving retrieval times				y	y	
EPR Implemented	Patient Digital Access	• To enable patients access to an electronic version of their records through utilising a “portal” approach; this element will be implemented in line with national requirements for patients access to their records				y	y	